February 21, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0558-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in occupational medicine, preventive medicine and public health. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 27 year-old male who sustained a work related injury on ___. The patient reported that while at work he lifted a garbage can from the ground and felt immediate back pain with cramping. The patient underwent X-Rays and an MRI. The MRI showed a right HNP at L3-L4 with impingement upon the L3 right nerve root. L5-S1 level also has a right paracentral herniation, impinging upon the right S1 nerve root, with swelling of the root. He has been treated with oral medications, TENS unit, and electrical neuromuscular stimulator.

Requested Services

Neuromuscular Electrical Stimulator

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___. The ___ physician reviewer indicated that it is not clear whether the etiology of this patient's back pain is discogenic or musculoligamentous in nature. The ___ physician reviewer noted that the therapy notes indicated that the patient did not have positive neurological findings. The ___

physician reviewer also noted that the patient never improved with therapy or medication changes. The ___ physician reviewer further noted that the documentation provided did not show that any form of electrical stimulation was helpful in this patient's therapy. The ___ physician reviewer explained that it is not clear what the requested BMR NT 2000 unit offers above and beyond the TENS unit. The ___ physician reviewer noted that there is no support of the use of a TENS in isolation for treatment of myofascial pain. The ___ physician reviewer explained that one of the most recent studies reviewed only mentioned the success of TENS in concert with other treatment. (Hou CR et al. Immediate effects of various physical therapeutic modalities on cervical myofascial pain and trigger-point sensitivity. Arch Phys Med Rehabil 2002; 83(10): 1406-14.) The ___ physician reviewer noted that it appears to be important to integrated exercise with TENS treatment. The ___ physician reviewer explained that another study found that studies of various treatments, including TENS did not have support in the medical literature for treatment of myofascial pain syndrome beyond 4 weeks. (Fargas-Babjak A. Acupuncture, transcutaneous electrical nerve stimulation, and laser therapy in chronic pain. Clin J Pain 2001; 17(4 Suppl): S105-13.) The ___ physician reviewer noted that the patient was in an acute phase of treatment for his low back pain. The ___ physician reviewer explained that there are other interventions that are appropriate for pain management at that time. The ___ physician reviewer also explained that there is not evidence available supporting the long-term use of neuromuscular electrical stimulation for pain management. Therefore, the ___ physician consultant concluded that the Neuromuscular Electrical Stimulator is not medically necessary to treat this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

___

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 21st day of February 2003.